CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2159	**Date: February 15, 2011**
	Change Request 7079

Transmittal 2109 is rescinded and replaced by Transmittal 2159 issued February 15, 2011. For Pub. 100-02 and Pub. 100-04, the addition and definition of 'voluntary advance care planning' as a specified element of the AWV has been removed and the post implementation contact information has been changed. For Pub. 100-04 only, Business Requirement 7079-04.3.1 and section 140.3 of the manual indicate 12X & 13X payment methodology is under the MPFS and also clarifies that for TOBs 71X & 77X, AWV does not qualify for separate payment with another encounter. All other information remains the same.

SUBJECT: Annual Wellness Visit (AWV), Including Personalized Prevention Plan Services (PPPS)

I. SUMMARY OF CHANGES: Pursuant to section 4103 of the Affordable Care Act of 2010 (ACA), the Centers for Medicare and Medicaid Services (CMS) amended sections 411.15(a)(1) and 411.15 (k)(15) of 42 CFR (list of examples of routine physical examinations excluded from coverage) effective for services furnished on or after January 1, 2011. This expanded coverage is subject to certain eligibility and other limitations that allow payment for an annual wellness visit (AWV), including personalized prevention plan services (PPPS), for an individual who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage period, and has not received either an initial preventive physical examination (IPPE) or an AWV providing PPPS within the past 12 months. Medicare coinsurance and Part B deductibles do not apply.

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: April 4, 2011

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	12/Table of Contents
R	12/30.6.1.1/Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV)
R	12/100.1.1/Evaluation and Management (E/M) Services
R	18/Table of Contents

R	18/80/Initial Preventive Physical Examination (IPPE)
R	18/80.1/Healthcare Common Procedure Coding System (HCPCS) Coding for the IPPE
R	18/80.2/A/B Medicare Administrative Contractor (MAC) and Contractor Billing Requirements
R	18/80.3/A/B MAC and Fiscal Intermediary (FI) Billing Requirements
R	18/80.3.1/Rural Health Clinic (RHC)/Federally Qualified Health Center (FQHC) Special Billing Instructions
R	18/80.3.3/Outpatient Prospective Payment System (OPPS) Hospital Billing
R	18/80.4/Coinsurance and Deductible
N	18/140/Annual Wellness Visit
N	18/140.1/Healthcare Common Procedure Coding System (HCPCS) Coding for the AWV
N	18/140.2/A/B Medicare Administrative Contractor (MAC) and Carrier Billing Requirements
N	18/140/3/A/B MAC and Fiscal Intermediary (FI) Billing Requirements
N	18/140/4/Rural Health Clinic (RHC)/Federally Qualified Health Center (FQHC) Special Billing Instructions
N	18/140.5/Coinsurance and Deductible
N	18/140/6/Common Working File (CWF) Edits
N	18/140.7/Medicare Summary Notices (MSNs), Remittance Advice Remark Codes (RARCs), Claims Adjustment Reason Codes (CARCs), and Advance Beneficiary Notices (ABNs)

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2159	Date: February 15, 2011	Change Request: 7079

Transmittal 2109 is rescinded and replaced by Transmittal 2159, issued February 15, 2011. For Pub. 100-02 and Pub. 100-04, the addition and definition of 'voluntary advance care planning' as a specified element of the AWV has been removed and the post implementation contact information has been changed. For Pub. 100-04 only, Business Requirement 7079-04.3.1 and section 140.3 of the manual indicate 12X & 13X payment methodology is under the MPFS and also clarifies that for TOBs 71X & 77X, AWV does not qualify for separate payment with another encounter. All other information remains the same.

SUBJECT: Annual Wellness Visit (AWV), Including Personalized Prevention Plan Services (PPPS)

Effective Date: January 1, 2011
Implementation Date: April 4, 2011

I. GENERAL INFORMATION

A. Background: Pursuant to section 4103 of the Affordable Care Act (ACA) of 2010, the Centers for Medicare & Medicaid Services (CMS) amended sections 411.15(a) (1) and 411.15 (k) (15) of 42 CFR (list of examples of routine physical examinations excluded from coverage) effective for services furnished on or after January 1, 2011. This expanded coverage is subject to certain eligibility and other limitations that allow payment for an annual wellness visit (AWV), including personalized prevention plan services (PPPS), for an individual who is no longer within the 12 months of the effective date of his or her first Medicare Part B coverage period, and has not received either an initial preventive physical examination (IPPE) or an AWV within the past 12 months. Medicare coinsurance and Part B deductibles do not apply.

B. Policy: This AWV will include the establishment of, or update to, the individual's medical and family history, measurement of his or her height, weight, body-mass index or waist circumference, and blood pressure with the goal of health promotion and disease detection and fostering the coordination of the screening and preventive services that may already be covered and paid for under Medicare Part B. Coverage is available for an AWV that meets the following requirements:

1. It is performed by a health professional;

2. It is furnished to an eligible beneficiary who is no longer within 12 months after the effective date of his/her first Medicare Part B coverage period, and he/she has not received either an IPPE or an AWV providing a PPPS within the past 12 months.

See Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 280.5, for coverage benefit questions, and Pub. 100-04, Medicare Claims Processing Manual, chapter 12, sections 30.6.1.1 and 100.1.1, and chapter 18, section 140, for detailed claims processing information regarding the AWV, including definitions of: (1) detection of cognitive impairment, (2) eligible beneficiary, (3) establishment of, or an update to, an individual's medical/family history, (4&5) first and subsequent AWVs providing PPPS, (6) health professional, and, (7) review of an individual's functional ability/level of safety.

NOTE: This change request (CR) does not impact claims for supplemental payments to Federally Qualified Health Centers (FQHCs) under contract with Medicare Advantage Plans.

NOTE: In addition, effective for services furnished on or after January 1, 2011, sections 4103 and 4104 of the ACA provide for a waiver of the Medicare coinsurance and Part B deductible requirements for the AWV. See CR 7012, Transmittal 739, dated July 30, 2010, for information related to the waiver that applies to preventive services, as well as the AWV.

NOTE: Two new HCPCS codes, G0438 - Annual wellness visit, includes a personalized prevention plan of service (PPPS), first visit, (Short descriptor – Annual wellness first) and G0439 - Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit, (Short descriptor – Annual wellness subseq) will be implemented January 1, 2011, through the Medicare Physician Fee Schedule Database (MPFSDB) and Integrated Outpatient Code Editor (IOCE).

II. BUSINESS REQUIREMENTS

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7079-04.1	Effective for dates of service on and after January 1, 2011, contractors and shared systems maintainers (SSMs) shall pay claims containing HCPCS G0438 or G0439 when billed for an AWV as described in Pub. 100-02, chapter 15, section 280.5, and Pub. 100-04, chapter 12, section 30.6.1.1 and 100.1.1 and chapter 18, sections 140-140.7.	X		X	X		X				
7079-04.1.1	When paying claims for AWVs, HCPCS G0438 or G0439, contractors shall use the following new message: Medicare Summary Notice (MSN) 18.25: "Your Annual Wellness Visit has been approved. You will qualify for another Annual Wellness Visit 12 months after the date of this visit." Spanish Version "Su Visita Anual de Bienestar ha sido aprobada. Usted tendrá derecho a otra Visita Anual de Bienestar 12 meses después de la fecha de esta visita."	X		X	X		X				
7079-04.1.2	For professional claims, contractors shall recognize that the Type of Service is 1.	X			X						
7079-04.2	Contractors shall waive the deductible and coinsurance/copayment for the AWV	X		X	X		X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	reported under HCPCS G0438 or G0439 effective for claims with dates of service on or after January 1, 2011.										
7079-04.3	Contractors shall pay for AWV claims containing HCPCS G0438 or G0439 only when this service is submitted on one of the following Type of Bills (TOBs): 12X, 13X, 22X, 23X, 71X, 77X, AND 85X.	X		X			X				
7079-04.3.1	Contractors shall pay claims for the AWV containing HCPCS G0438 or G0439 as follows: • TOBs 12X (Hospital Inpatient (IP) Part B) and 13X (Hospital Outpatient (OP)) based on MPFS, • TOBs 22X (SNF IP Part B) and 23X (SNF OP) based on the MPFS, • TOBs 71X (RHCs) and 77X (FQHCs) based on the all-inclusive rate, and • TOB 85X (Critical Access Hospitals (CAHs)) based on reasonable cost. NOTE: For TOBs 71X & 77X the AWV does not qualify for separate payment with another encounter.	X		X			X				
7079-04.3.2	Contractors shall pay for an AWV at hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission in accordance with the terms of the Maryland waiver.	X		X			X				
7079-04.3.3	Contractors shall pay claims for an AWV containing HCPCS G0438 or G0439 and revenue codes 096X, 097X, and 098X on TOB 85X CAH Method II under the MPFS.	X		X			X				
7079-04.4	Contractors shall return to provider	X		X			X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	claims for an AWV, HCPCS G0438 or G0439, billed on other than TOBs 12X, 13X, 22X, 23X, 71X, 77X, and 85X.										
7079-04.5	For claims with dates of service on or after January 1, 2011, CWF shall create an edit to allow payment for AWV HCPCS G0438 once in a lifetime.									X	
7079-04.5.1	Contractors shall line-item deny claims for a first AWV, HCPCS G0438, where a previous first AWV, HCPCS G0438, is paid in history using the following messages: CARC 149: "Lifetime benefit maximum has been reached for this service/benefit category." RARC N117: "This service is paid only once in a patient's lifetime**.** MSN 20.12: "This service was denied because Medicare only covers this service once a lifetime." Spanish Version: "Este servicio fue negado porque Medicare sólo cubre este servicio una vez en la vida." Group Code - PR	X		X	X		X				
7079-04.6	For claims with dates of service on and after January 1, 2011, CWF shall not allow payment for a subsequent AWV, HCPCS G0439, if a previous AWV, HCPCS G0438 or G0439, is paid in history within the past 12 months. CWF shall count 11 full months starting with the month a beneficiary's last AWV (HCPCS G0438 or G0439) is paid in the history file.									X	
7079-04.6.1	When denying claims for subsequent AWV HCPCS G0439 because a previous	X		X	X		X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	AWV, HCPCS G0438 or G0439, is paid in history within the past 12 months, contractors shall use the following messages: (New) MSN 18.26: "This service was denied because it occurred too soon after your last covered Annual Wellness Visit. Medicare only covers one Annual Wellness Visit within a 12-month period.' Spanish Version: "Este servicio fue negado porque ocurrió antes del período de 12 meses de su última Visita Anual de Bienestar. Medicare sólo paga por una Visita Anual de Bienestar dentro de un período de 12 meses." CARC 119: "Benefit maximum for this time period or occurrence has been reached." RARC N130: "Consult plan benefit documents/ guidelines for information about restrictions for this service." Group Code – PR										
7079-04.7	For claims with dates of service on and after January 1, 2011, CWF shall not allow payment for HCPCS G0438 or G0439 if payment for a previous IPPE, HCPCS G0402, is paid in history within the last 12 months. CWF shall count 11 full months starting with the month a beneficiary's IPPE is paid in the history file.									X	
7079-04.7.1	When denying claims for AWV HCPCS G0438 or G0439 because an IPPE, HCPCS G0402, is paid in history within the past 12 months, contractors shall use	X		X	X		X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	the following messages: (New) MSN 18.27: "This service was denied because it occurred too soon after your Initial Preventive Physical Exam." Spanish Version: "Este servicio fue negado porque ocurrió demasiado pronto después de su examen físico preventivo inicial." CARC 119: "Benefit maximum for this time period or occurrence has been reached." RARC N130: "Consult plan benefit documents/ guidelines for information about restrictions for this service." Group Code - PR										
7079-04.8	For claims with dates of service on and after January 1, 2011, CWF shall not allow payment for an AWV, HCPCS G0438 or G0439, if another AWV, HCPCS G0438 or G0439, is billed for a date of service within 12 months after the effective date of the beneficiary's first Medicare Part B coverage period.									X	
7079-04.8.1	Contractors shall line-item deny claims for an AWV, G0438 or G0439, rendered within the first 12 months after the effective date of a beneficiary's first Medicare Part B coverage period using the following messages: (New) MSN 18.24: "This service was denied. Medicare doesn't cover an Annual Wellness Visit within the first 12 months of your Medicare Part B coverage. Medicare does cover a one-time initial preventive physical exam ("Welcome to Medicare" physical exam)	X		X	X		X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	within the first 12 months of your Medicare Part B coverage". Spanish Version: "Este servicio fue negado. Medicare no cubre la Visita Anual de Bienestar durante los primeros 12 meses de su inscripción a la Parte B de Medicare. Medicare cubre un examen físico preventivo ("Bienvenido a Medicare") durante los primeros 12 meses de su inscripción a la Parte B de Medicare." CARC 26: "Expenses incurred prior to coverage" RARC N130: "Consult plan benefit documents/ guidelines for information about restrictions for this service." Group Code - PR										
7079-04.9	For claims with dates of service on and after January 1, 2011, CWF shall apply appropriate updates to the Next Eligibility Dates file. **NOTE:** Appropriate updates include modifications to the HIMR (PRVN), Provider Inquiry, HUQA, and Extract Records on the Next Generation Desktop (NGD) and the Medicare Beneficiary Database (MBD).						X	X		X	MBD NGD
7079-04.10	For claims with dates of service on and after January 1, 2011, the Multi-Carrier System Desktop Tool shall display the AWV visits in a format equivalent to the CWF HIMR screen.							X			
7079-04.11	Contractors shall not search and adjust AWV claims, G0438 or G0439, paid for more than once within a 12-month period processed prior to the implementation of this CR. However, contractors may	X		X	X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	adjust claims brought to their attention.										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7079-04.12	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
	NA

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Coverage: Pat Brocato-Simons, patricia.brocatosimons@cms.hhs.gov, 410-786-0261, Part A Claims Processing: Bill Ruiz, William.Ruiz@cms.hhs.gov, 410-786-9283, Part B Claims Processing: Tom Dorsey, Thomas.Dorsey@cms.hhs.gov, 410-786-7434.

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Intermediaries (RHHIs):* No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs:* The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners

Table of Contents
(Rev. 2159, Issued: 02-15-11)

30.6.1.1 – Initial Preventive Physical Examination *(IPPE) and Annual Wellness Visit (AWV)*

(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

A. Definitions

1. Initial Preventive Physical Examination (IPPE)

The initial preventive physical examination (IPPE), or "Welcome to Medicare Visit" (WMV) is a preventive evaluation and management service (E/M), allowed by Section 611 of the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003, that includes:

(1) review of the individual's medical and social history with attention to modifiable risk factors for disease detection,

(2) review of the individual's potential (risk factors) for depression or other mood disorders,

(3) review of the individual's functional ability and level of safety,

(4) a physical examination to include measurement of the individual's height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate by the examining physician or qualified nonphysician practitioner (NPP),

(5) performance and interpretation of an electrocardiogram (EKG),

(6) education, counseling, and referral, as deemed appropriate, based on the results of the review and evaluation services described in the previous 5 elements, and,

(7) education, counseling, and referral including a brief written plan (e.g., a checklist or alternative) provided to the individual for obtaining the appropriate screening and other preventive services.

Effective January 1, 2007, Section 5112 of the Deficit Reduction Act of 2005 allows for one ultrasound screening for Abdominal Aortic Aneurysm (AAA), HCPCS code G0389, as a result of a referral from an IPPE. This service is not subject to the Part B annual deductible. For AAA physician/practitioner billing, correct coding, and payment policy, refer to chapter 18, §110, of this manual.

Effective January 1, 2009, Section 101 (b) of the Medicare Improvement for Patients and Providers Act (MIPPA) of 2008 requires the addition of the measurement of an individual's body mass index and, upon an individual's consent, end-of-life planning, to the IPPE. Also, effective January 1, 2009, MIPPA removes the screening electrocardiogram (EKG) as a mandatory service of the IPPE. MIPPA requires that there

be education, counseling, and referral for an EKG, as appropriate. This is a once-in-a-lifetime screening EKG as a result of a referral from an IPPE.

The MIPPA of 2008 allows for possible future payment for additional preventive services not otherwise described in Title XVIII of the Social Security Act (the Act) that identify medical conditions or risk factors for eligible individuals if the Secretary determines through the national coverage determination (NCD) process (as defined in Section 1869(f)(1)(B) of the Act) that they are: (1) reasonable and necessary for the prevention or early detection of illness or disability, (2) recommended with a grade of A or B by the United States Preventive Services Task Force *(USPSTF),* and, (3) appropriate for individuals entitled to benefits under Part A or enrolled under Part B, or both. MIPPA requires that there be education, counseling, *and* referral for additional preventive services, as appropriate, under the IPPE, if the Secretary determines in the future that such services are covered.

2. Annual Wellness Visit (AWV)

Effective January 1, 2011, Section 4103 of the Affordable Care Act (ACA), allows for a preventive physical examination, called the annual wellness visit (AWV), and includes personal prevention plan services (PPPS). The AWV is a new annual Medicare preventive physical examination, available for eligible beneficiaries, and identified by new HCPCS codes G0438 (Annual wellness visit, including PPPS, first visit) and G0439 (Annual wellness visit, including PPPS, subsequent visit). Definitions relative to the AWV are included at Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 280.5.

First AWV services providing PPPS (HCPCS G0438) are a 'one time' allowed Medicare benefit and include the following key elements furnished to an eligible beneficiary by a health professional:

- *Establishment of the individual's medical/family history,*
- *Measurement of the individual's height, weight, body mass index (or waist circumference, if appropriate), blood pressure (BP), and other routine measurements as deemed appropriate, based on the individual's medical and family history,*
- *Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual,*
- *Detection of any cognitive impairment that the individual may have,*
- *Review of an individual's potential risk factors for depression , including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available*

standardized screening tests designed for this purpose and recognized by national professional medical organizations,

- *Review of the individual's functional ability and level of safety, based on direct observation of the individual, or the use of appropriate screening questions or a screening questionnaire, which the health professional may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations,*

- *Establishment of a written screening schedule for the individual, such as a checklist for the next 5 to 10 years, as appropriate, based on recommendations of the USPSTF and Advisory Committee of Immunizations Practices (ACIP), the individual's health status, screening history, and age-appropriate preventive services covered by Medicare,*

- *Establishment of a list of risk factors and conditions of which primary, secondary, or tertiary interventions are recommended or underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an IPPE, and a list of treatment options and their associated risks and benefits,*

- *Provision of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition, and,*

- *Any other element(s) determined appropriate by the Secretary through the NCD process.*

Subsequent AWV services providing PPPS (HCPCS G0439) include the following key elements furnished to an eligible beneficiary by a health professional:

- *Update to the individual's medical /family history,*

- *Measurements of an individual's weight (or waist circumference), BP, and other routine measurements as deemed appropriate, based on the individual's medical and family history,*

- *Update to the list of the individual's current medical providers and suppliers that are regularly involved in providing medical care to the individual as that list was developed for the first AWV providing PPPS,*

- *Detection of any cognitive impairment that the individual may have,*

- *Update to the individual's written screening schedule as developed at the first AWV providing PPPS,*

- *Update to the individual's list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for the individual, as that list was developed at the first AWV providing PPPS,*

- *Furnish appropriate personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs, and,*

- *Any other element determined appropriate by the Secretary through the NCD process.*

Preventive services are separately covered under Medicare Part B. See chapter 18 *of this manual.*

B. Who May Perform

The IPPE *and the AWV* may be performed by a doctor of medicine or osteopathy as defined in Section 1861(r) (1) of the Act, by a qualified NPP (nurse practitioner, physician assistant or clinical nurse specialist), *or for the AWV, by a health professional (a medical professional including a health educator, registered dietitian, nutrition professional, or other licensed practitioner) or a team of such medical professionals who are working under the direct supervision of a physician.* The contractor pays the appropriate physician fee schedule amount based on the rendering National Provider Identification (NPI) number.

C. Eligibility

1. IPPE

As a result of the MMA 2003, Medicare will pay for one IPPE per beneficiary per lifetime. A beneficiary is eligible when he/*she* first enrolls in Medicare Part B. *For beneficiaries enrolled* on or after January 1, 2005, *beneficiaries must have received their IPPE* within the first 6 months *of Medicare coverage. The MIPPA extends the eligibility period for an IPPE to 12 months effective January 1, 2009.*

Beneficiaries in their first 12 months of Part B coverage will continue to be eligible for only the IPPE. Medicare continues to pay for only one IPPE per beneficiary per lifetime.

2. AWV

As a result of the ACA, effective January 1, 2011, Medicare will pay for an AWV for a beneficiary who is no longer within 12 months after the effective date of his/her first Medicare Part B coverage period, and he/she has not received either an IPPE or an

AWV providing PPPS within the past 12 months. Medicare pays for only one first AWV (HCPCS G0438), per beneficiary per lifetime, and all subsequent wellness visits must be billed as a subsequent AWV (HCPCS G0439).

Beneficiaries in their first 12 months of Part B coverage will continue to be eligible for only the IPPE (see 30.6.1.1.A.1).

D. Deductible and Coinsurance

1. IPPE

The Medicare deductible and coinsurance apply for the IPPE provided before January 1, 2009.

The Medicare deductible is waived effective for the IPPE provided on or after January 1, 2009. However, the applicable coinsurance continues to apply for the IPPE provided on or after January 1, 2009.

As a result of the ACA, effective for the IPPE provided on or after January 1, 2011, the Medicare deductible *and coinsurance* (for HCPCS code G0402 *only*) *are* waived.

2. AWV

As a result of the ACA, effective January 1, 2011, the Medicare deductible and coinsurance for the AWV (HCPCS G0438 and G0439) are waived.

E. The EKG Component *of the IPPE*

Under the MMA of 2003, if the physician or qualified NPP is not able to perform both the examination and the screening EKG, an arrangement may be made to ensure that another physician or entity performs the screening EKG and reports the EKG separately using the appropriate HCPCS G code(s) identified in *F*.1. of this section. When the screening EKG is performed, the primary physician or qualified NPP shall document the results of the screening EKG into the beneficiary's medical record to complete and bill for the IPPE benefit.

NOTE: Both components of the IPPE (the examination and the screening EKG) must be performed before the claims can be submitted by the physician, qualified NPP, and/or entity.

MIPPA 2008 changes the once-in-a-lifetime screening EKG from a mandated service to a service that may be performed, as appropriate, with a referral from an IPPE. *When an EKG is furnished with the IPPE, the deductible and coinsurance will continue to apply for EKG services only.*

F. HCPCS Codes Used to Bill the IPPE *or AWV*

1. HCPCS Codes Used to Bill the IPPE

For IPPE and EKG services provided prior to January 1, 2009, the physician or qualified NPP shall bill HCPCS code G0344 for the physical examination performed face-to-face, and HCPCS code G0366 for performing a screening EKG that includes both the interpretation and report. If the primary physician or qualified NPP performs only the examination, he/she shall bill HCPCS code G0344 only. The physician or entity that performs the screening EKG that includes both the interpretation and report shall bill HCPCS code G0366. The physician or entity that performs the screening EKG tracing only (without interpretation and report) shall bill HCPCS code G0367. The physician or entity that performs the interpretation and report only (without the EKG tracing) shall bill HCPCS code G0368. Medicare will pay for a screening EKG only as part of the IPPE. HCPCS codes G0344, G0366, G0367 and G0368 will not be billable codes effective on or after January 1, 2009.

Effective for a beneficiary who has the IPPE on or after January 1, 2009, and within his/her 12-month enrollment period of Medicare Part B, the IPPE and screening EKG services are billable with the appropriate HCPCS G code(s).

The physician or qualified NPP shall bill HCPCS code G0402 for the physical examination performed face-to-face with the patient.

The physician or entity shall bill HCPCS code G0403 for performing the complete screening EKG that includes the tracing, interpretation and report.

The physician or entity that performs the screening EKG tracing only (without interpretation and report) shall bill HCPCS code G0404.

The physician or entity that performs the screening EKG interpretation and report only, (without the EKG tracing) shall bill HCPCS code G0405.

2. HCPCS Codes Used to Bill the AWV

For the first AWV provided on or after January 1, 2011, the health professional shall bill HCPCS G0438 (Annual wellness visit, including PPPS, first visit). This is a once per beneficiary per lifetime allowable Medicare benefit.

All subsequent AWVs shall be billed with HCPCS G0439 (Annual Wellness Visit, including PPPS, subsequent visit). In the event that a beneficiary selects a new health professional to complete a subsequent AWV, the new health professional will continue to bill the subsequent AWV with HCPCS G0439.

NOTE: For an IPPE *or AWV* performed during the global period of surgery refer to *chapter* 12, §30.6.6 of this manual for reporting instructions.

G. Documentation *for the IPPE or AWV*

The physician and qualified NPP, *or for AWV the health professional,* shall use the appropriate screening tools typically used in routine physician practice. Physicians, qualified NPPs*, and medical professionals* are required to use the 1995 and 1997 E/M documentation guidelines to document the medical record with the appropriate clinical information. (http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp). All referrals and a written medical plan must be included in this documentation.

H. Reporting a Medically Necessary E/M Service Furnished *During the Same Encounter as an IPPE or AWV*

When the physician or qualified NPP, or *for AWV the health professional,* provides a *significant, separately identifiable* medically necessary E/M service in addition to the IPPE *or an AWV*, CPT codes 99201 – 99215 may be *reported* depending on the clinical appropriateness of the circumstances. CPT Modifier –25 shall be appended to the medically necessary E/M service identifying this service as a significant, separately identifiable service from the IPPE *or AWV code* reported (HCPCS code G0344 or G0402, whichever applies based on the date the IPPE is performed, or HCPCS code *G0438 or G0439 whichever AWV code applies).*

NOTE: Some of the components of a medically necessary E/M service (e.g., a portion of history or physical exam portion) may have been part of the IPPE or *AWV* and should not be included when determining the most appropriate level of E/M service to be billed for the medically necessary, *separately identifiable,* E/M service.

100.1.1 –Evaluation and Management (E/M) Services

(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

A. General Documentation Instructions and Common Scenarios

For a given encounter, the selection of the appropriate level of E/M service should be determined according to the code definitions in the American Medical Association's Current Procedural Terminology (CPT) and any applicable documentation guidelines.

For purposes of payment, E/M services billed by teaching physicians require that they personally document at least the following:

- That they performed the service or were physically present during the key or critical portions of the service when performed by the resident; and,

- The participation of the teaching physician in the management of the patient.

When assigning codes to services billed by teaching physicians, reviewers will combine the documentation of both the resident and the teaching physician. Documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician. On medical review, the combined entries into the medical record by the teaching physician and the resident constitute the documentation for the service and together must support the medical necessity of the service. Following are three common scenarios for teaching physicians providing E/M services:

Scenario 1: The teaching physician personally performs all the required elements of an E/M service without a resident. In this scenario the resident may or may not have performed the E/M service independently*, separate and apart from the service the teaching physician may have performed.* In the absence of a note by a resident, the teaching physician must document as he/she would document an E/M service in a nonteaching setting. Where a resident has written notes, the teaching physician's note may reference the resident's note. The teaching physician must document that he/she performed the critical or key portion(s) of the service, and that he/she was directly involved in the management of the patient. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

Scenario 2: The resident performs the elements required for an E/M service in the presence of, or jointly with, the teaching physician and the resident documents the service. In this case, the teaching physician must document that he/she was present during the performance of the critical or key portion(s) of the service and that he/she was directly involved in the management of the patient. The teaching physician's note should reference the resident's note. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity and the level of the service billed by the teaching physician.

Scenario 3: The resident performs some or all of the required elements of the service in the absence of the teaching physician and documents his/her service. The teaching physician independently performs the critical or key portion(s) of the service with or without the resident present and, as appropriate, discusses the case with the resident. In this instance, the teaching physician must document that he/she personally saw the patient, personally performed critical or key portions of the service, and participated in the management of the patient. The teaching physician's note should reference the resident's note. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

Following are examples of minimally acceptable documentation for each of these scenarios:

Scenario 1: Admitting Note: "I performed a history and physical examination of the patient and discussed his management with the resident. I reviewed the resident's note and agree with the documented findings and plan of care."

Follow-up Visit: "Hospital Day #3. I saw and evaluated the patient. I agree with the findings and the plan of care as documented in the resident's note."

Follow-up Visit: "Hospital Day #5. I saw and examined the patient. I agree with the resident's note except the heart murmur is louder, so I will obtain an echo to evaluate."

(**NOTE:** In this scenario if there are no resident notes, the teaching physician must document as he/she would document an E/M service in a non-teaching setting.)

Scenario 2: Initial or Follow-up Visit: "I was present with the resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note."

Follow-up Visit: "I saw the patient with the resident and agree with the resident's findings and plan."

Scenario 3: Initial Visit: "I saw and evaluated the patient. I reviewed the resident's note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs."

Initial or Follow-up Visit: "I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note."

Follow-up Visit: "See resident's note for details. I saw and evaluated the patient and agree with the resident's finding and plans as written."

Follow-up Visit: "I saw and evaluated the patient. Agree with resident's note but lower extremities are weaker, now 3/5; MRI of L/S Spine today."

Following are examples of unacceptable documentation:

"Agree with above" followed by legible countersignature or identity;

"Rounded, Reviewed, Agree" followed by legible countersignature or identity;

"Discussed with resident, agree" followed by legible countersignature or identity;

"Seen and agree" followed by legible countersignature or identity;

"Patient seen and evaluated" followed by legible countersignature or identity; and,

A legible countersignature or identity alone.

Such documentation is not acceptable, because the documentation does not make it possible to determine whether the teaching physician was present, evaluated the patient, and/or had any involvement with the plan of care.

B. E/M Service Documentation Provided By Students

Any contribution and participation of a student to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable, but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service meeting the requirements set forth in this section for teaching physician billing.

Students may document services in the medical record. However, the documentation of an E/M service by a student that may be referred to by the teaching physician is limited to documentation related to the review of systems and/or past family/social history. The teaching physician may not refer to a student's documentation of physical exam findings or medical decision making in his or her personal note. If the medical student documents E/M services, the teaching physician must verify and redocument the history of present illness as well as perform and redocument the physical exam and medical decision making activities of the service.

C. Exception for E/M Services Furnished in Certain Primary Care Centers

Teaching physicians providing E/M services with a GME program granted a primary care exception may bill Medicare for lower- and mid-level E/M services provided by residents. For the E/M codes listed below, teaching physicians may submit claims for services furnished by residents in the absence of a teaching physician:

New Patient	Established Patient
99201	99211
99202	99212
99203	99213

For services provided on or after January 1, 2005, the following code is included under the primary care exception: *HCPCS code* G0344 - Initial preventive physical examination; face-to-face visit services limited to new beneficiary during the first 6 months of Medicare enrollment.

For services provided on or after January 1, 2009, the following code is included under the primary care exception: HCPCS code G0402 - Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment.

Effective January 1, 2011, the following codes are included under the primary care exception: HCPCS code G0438 – Annual wellness visit, includes a personalized prevention plan of service (PPPS), first visit, and HCPCS code G0439 – Annual wellness visit, includes a personalized prevention plan of service, subsequent visit.

If a service other than those listed above needs to be furnished, then the general teaching physician policy set forth in §100.1 applies. For this exception to apply, a center must attest in writing that all the following conditions are met for a particular residency program. Prior approval is not necessary, but centers exercising the primary care exception must maintain records demonstrating that they qualify for the exception.

The services must be furnished in a center located in the outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining direct GME payments to a teaching hospital by the hospital's *fiscal intermediary (*FI*)*. This requirement is not met when the resident is assigned to a physician's office away from the center or makes home visits. In the case of a non-hospital entity, verify with the FI that the entity meets the requirements of a written agreement between the hospital and the entity set forth at 42 CFR 413.78(e)(3)(ii).

Under this exception, residents providing the billable patient care service without the physical presence of a teaching physician must have completed at least 6 months of a GME approved residency program. Centers must maintain information under the provisions at 42 CFR 413.79(a)(6).

Teaching physicians submitting claims under this exception may not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability. The teaching physician must:

- Not have other responsibilities (including the supervision of other personnel) at the time the service was provided by the resident;

- Have the primary medical responsibility for patients cared for by the residents;

- Ensure that the care provided was reasonable and necessary;

- Review the care provided by the resident during or immediately after each visit. This must include a review of the patient's medical history, the resident's findings on physical examination, the patient's diagnosis, and treatment plan (i.e., record of tests and therapies); and,

- Document the extent of his/her own participation in the review and direction of the services furnished to each patient.

Patients under this exception should consider the center to be their primary location for health care services. The residents must be expected to generally provide care to the same group of established patients during their residency training. The types of services furnished by residents under this exception include:

- Acute care for undifferentiated problems or chronic care for ongoing conditions including chronic mental illness;

- Coordination of care furnished by other physicians and providers; and,

- Comprehensive care not limited by organ system or diagnosis.

Residency programs most likely qualifying for this exception include family practice, general internal medicine, geriatric medicine, pediatrics, and obstetrics/gynecology. Certain GME programs in psychiatry may qualify in special situations such as when the program furnishes comprehensive care for chronically mentally ill patients. These would be centers in which the ranges of services the residents are trained to furnish, and actually do furnish, include comprehensive medical care as well as psychiatric care. For example, antibiotics are being prescribed as well as psychotropic drugs.

Medicare Claims Processing Manual

Chapter 18 –Preventive and Screening Services

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(Rev. 2159, Issued: 02-15-11)

80 – Initial Preventive Physical Examination (IPPE)

(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

*(**NOTE:** For billing and payment requirements for the Annual Wellness Visit, see chapter 18, section 140, of this manual.)*

Background: Effective for services furnished on or after January 1, 2005, Section 611 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) provides for coverage under Part B of one initial preventive physical examination (IPPE) for new beneficiaries only, subject to certain eligibility and other limitations. *CMS* amended §§411.15 (a)(1) and 411.15 (k)(11) of the Code of Federal Regulations (CFR) to permit payment for an IPPE as described at 42 CFR §410.16, added by 69 FR 66236, 66420 (November 15, 2004) not later than 6 months after the date the individual's first coverage period begins under Medicare Part B.

Under the MMA of 2003, the IPPE may be performed by a doctor of medicine or osteopathy as defined in section 1861 (r)(1) of the Social Security Act (the Act) or by a qualified mid-level nonphysician practitioner (NPP) (nurse practitioner, physician assistant or clinical nurse specialist), not later than 6 months after the date the individual's first coverage begins under Medicare Part B. (See section 80.3 for a list of bill types of facilities that can bill fiscal intermediaries (FIs) for this service.) This examination will include: (1) review of the individual's medical and social history with attention to modifiable risk factors for disease detection, (2) review of the individual's potential (risk factors) for depression or other mood disorders, (3) review of the individual's functional ability and level of safety; (4) a physical examination to include measurement of the individual's height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate by the examining physician or qualified nonphysician practitioner (NPP), (5) performance and interpretation of an electrocardiogram (EKG); (6) education, counseling, and referral, as deemed appropriate, based on the results of the review and evaluation services described in the previous 5 elements, and (7) education, counseling, and referral including a brief written plan (e.g., a checklist or alternative) provided to the individual for obtaining the appropriate screening and other preventive services, which are separately covered under Medicare Part B benefits. The EKG performed as a component of the IPPE will be billed separately. Medicare will pay for only one IPPE per beneficiary per lifetime. The Common Working File (CWF) will edit for this benefit.

As required by statute under the MMA of 2003, the total IPPE service includes an EKG, but the EKG is billed with its own unique HCPCS code(s). The IPPE does not include other preventive services that are currently separately covered and paid under Section 1861 of the Act under Medicare Part B screening benefits. (That is, pneumococcal, influenza and hepatitis B vaccines and their administration, screening mammography, screening pap smear and screening pelvic examinations, prostate cancer screening tests, colorectal cancer screening tests, diabetes outpatient self-management training services, bone mass measurements, glaucoma screening, medical nutrition therapy for individuals

with diabetes or renal disease, cardiovascular screening blood tests, and diabetes screening tests.)

Section 5112 of the Deficit Reduction Act of 2005 allows for one ultrasound screening for Abdominal Aortic Aneurysm (AAA) as a result of a referral from an IPPE effective January 1, 2007. For AAA physician/practitioner billing, correct coding, and payment policy information, refer to section 110 of this chapter.

Effective January 1, 2009, Section 101(b) of the Medicare Improvement for Patients and Providers Act (MIPPA) of 2008 updates the IPPE benefit described under the MMA of 2003. The MIPPA allows the IPPE to be performed not later than 12 months after the date the individual's first coverage period begins under Medicare Part B, requires the addition of the measurement of an individual's body mass index to the IPPE, adds end-of-life planning (upon an individual's consent) to the IPPE, and removes the screening EKG as a mandatory service of the IPPE. The screening EKG is optional effective January 1, 2009, and is permitted as a once-in-a-lifetime screening service as a result of a referral from an IPPE.

The MIPPA of 2008 allows for possible future payment for additional preventive services not otherwise described in Title XVIII of the Act that identify medical conditions or risk factors for eligible individuals if the Secretary determines through the national coverage determination (NCD) process (as defined in section 1869(f)(1)(B) of the Act) that they are: (1) reasonable and necessary for the prevention or early detection of illness or disability, (2) recommended with a grade of A or B by the United States Preventive Services Task Force, and, (3) appropriate for individuals entitled to benefits under Part A or enrolled under Part B, or both. MIPPA requires that there be education, counseling, *and* referral for additional preventive services, as appropriate, under the IPPE, if the Secretary determines in the future that such services are covered.

For the physician/practitioner billing correct coding and payment policy, refer to chapter 12, section 30.6.1.1, of this manual.

80.1 – *Healthcare Common Procedure Coding System (*HCPCS*)* Coding for the IPPE

(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

The HCPCS codes listed below were developed for the IPPE benefit effective January 1, 2005, for individuals whose initial enrollment is on or after January 1, 2005.

G0344: Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 6 months of Medicare enrollment

Short Descriptor: Initial Preventive Exam

G0366: Electrocardiogram, routine ECG with 12 leads; performed as a component of the initial preventive examination with interpretation and report

Short Descriptor: EKG for initial prevent exam

G0367: tracing only, without interpretation and report, performed as a component of the initial preventive examination

Short Descriptor: EKG tracing for initial prev

G0368: interpretation and report only, performed as a component of the initial preventive examination

Short Descriptor: EKG interpret & report preve

The following new HCPCS codes *were* developed for the IPPE benefit effective January 1, 2009, and replace*d* codes G0344, G0366, G0367, and G0368 shown above beginning with dates of service on or after January 1, 2009:

G0402: Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment

Short Descriptor: Initial Preventive exam

G0403: Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report

Short Descriptor: EKG for initial prevent exam

G0404: Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination

Short Descriptor: EKG tracing for initial prev

G0405: Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination

Short Descriptor: EKG interpret & report preve

80.2 – *A/B Medicare Administrative Contractor (MAC) and Contractor* Billing Requirements

(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

Effective for dates of service on and after January 1, 2005, through December 31, 2008, contractors shall recognize the HCPCS codes G0344, G0366, G0367, and G0368 shown above in §80.1 for an IPPE. The type of service (TOS) for each of *these* codes is as follows:

G0344: TOS = 1
G0366: TOS = 5
G0367: TOS = 5
G0368: TOS = 5

Contractors shall pay physicians or qualified nonphysician practitioners for only one IPPE performed not later than 6 months after the date the individual's first coverage begins under Medicare Part B, but only if that coverage period begins on or after January 1, 2005.

Effective for dates of service on and after January 1, 2009, contractors shall recognize the HCPCS codes G0402, G0403, G0404, and G0405 shown above in §80.1 for an IPPE. The *TOS* for each of *these* codes is as follows:

G0402: TOS = 1
G0403: TOS = 5
G0404: TOS = 5
G0405: TOS = 5

Under the MIPPA of 2008, contractors shall pay physicians or qualified nonphysician practitioners for only one IPPE performed not later than 12 months after the date the individual's first coverage begins under Medicare Part B *only if that coverage period begins on or after January 1, 2009*.

Contractors shall allow payment for a medically necessary Evaluation and Management (E/M) service at the same visit as the IPPE when it is clinically appropriate. Physicians and qualified nonphysician practitioners shall use CPT codes 99201-99215 to report an E/M with CPT modifier 25 to indicate that the E/M is a significant, separately identifiable service from the IPPE code reported (G0344 or G0402, whichever applies based on the date the IPPE is performed). Refer to *chapter* 12, § 30.6.1.1, of this manual for the physician/practitioner billing correct coding and payment policy regarding E/M services.

If the EKG performed as a component of the IPPE is not performed by the primary physician or qualified NPP during the IPPE visit, another physician or entity may perform and/or interpret the EKG. The referring physician or qualified NPP needs to make sure that the performing physician or entity bills the appropriate G code for the screening EKG, and **not** a CPT code in the 93000 series. **Both the IPPE and the EKG should be billed in order for the beneficiary to receive the complete IPPE service**. Effective for dates of service on and after January 1, 2009, the screening EKG is optional and is no longer a mandated service of an IPPE if performed as a result of a referral from an IPPE.

Should the same physician or NPP need to perform an additional medically necessary EKG in the 93000 series on the same day as the IPPE, report the appropriate EKG CPT code(s) with modifier 59, indicating that the EKG is a distinct procedural service.

Physicians or qualified nonphysician practitioners shall bill the contractor the appropriate HCPCS codes for IPPE on the Form CMS-1500 claim or an approved electronic format. The HCPCS codes for an IPPE and screening EKG are paid under the Medicare Physician Fee Schedule (MPFS). The appropriate deductible and coinsurance applies to codes G0344, G0366, G0367, G0368, G0403, G0404, and G0405. The deductible is waived for code G0402 but the coinsurance still applies.

80.3 – *A/B MAC* and Fiscal Intermediary *(FI)* Billing Requirements

(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

Contractors will pay for IPPE or EKG only when the services are submitted on one of the following *TOBs*: 12X, 13X, 22X, 71X, 73X and 85X.

Type of facility and setting determines the basis of payment:

- For the IPPE or the screening EKG tracing only performed on a 12X and 13X *TOB, hospital inpatient Part B and hospital outpatient,* for hospitals subject to the outpatient prospective payment system (OPPS), under the OPPS. Hospitals not subject to OPPS shall be paid under current methodologies.

- For services performed on an 85X TOB, Critical Access Hospitals *(CAHs)*, pay on reasonable cost.

- For services performed in a *skilled nursing facility*, TOB 22x, make payment for the technical component of the EKG based on the MPFS.

- For inpatient or outpatient services in hospitals in Maryland, make payment according to the *Health Services Cost Review Commission*.

- For services performed on a 12X *TOB*, Indian Health Services (IHS) hospitals, payment is made based on an all-inclusive ancillary per diem rate.

- For services performed on a 13X *TOB*, IHS hospitals, payment is made based on the all-inclusive rate (AIR).

- For services performed on an 85X *TOB*, IHS CAHs, payment is made based on an all-inclusive facility specific per visit rate.

All CAHs are paid for the technical or facility component of the IPPE itself. They are also paid for the technical component of the EKG, the tracing only, if the EKG is performed. Only CAHs *paid under the optional method* are paid for the professional component of the IPPE itself (in addition to the facility payment) *for charges under revenue* code 0960. If the EKG is performed, CAHs *paid under the optional method may* also be paid for the interpretation of the EKG (in addition to the payment for the tracing) when billed under revenue codes 0985 or 0986.

80.3.1 – *Rural Health Clinic (*RHC*)/Federally Qualified Health Center (*FQHC*)* Special Billing Instructions

(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

There are Initial Preventive Physical Examination (IPPE) instructions that are unique to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). Refer to chapter 9, section 150, of this manual for a description of these instructions.

80.3.3 – *Outpatient Prospective Payment System (*OPPS*)* Hospital Billing

(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

Hospitals subject to OPPS (TOBs 12X and 13X) must use modifier -25 when billing the IPPE G0344 along with *the* technical component of the EKG, G0367, on the same claim. The same is true when billing IPPE code G0402 along with the technical component of the screening EKG, code G0404. This is due to an OPPS Outpatient Code Editor (OCE) which contains an edit that requires a modifier -25 on any evaluation and management (E/M) HCPCS code if there is also a status "S" or "T" HCPCS procedure code on the claim.

80.4 – Coinsurance and Deductible

(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

The Medicare deductible and coinsurance apply for the IPPE provided before January 1, 2009.

The Medicare deductible is waived effective for the IPPE provided on or after January 1, 2009. Coinsurance continues to apply for the IPPE provided on or after January 1, 2009.

As a result of the Affordable Care Act, effective for the IPPE provided on or after January 1, 2011, the Medicare deductible and coinsurance (for HCPCS code G0402 only) are waived.

140 – Annual Wellness Visit (AWV)

(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

Pursuant to section 4103 of the Affordable Care Act of 2010, the Centers for Medicare & Medicaid Services (CMS) amended section 411.15(a)(1) and 411.15(k)(15) of 42 CFR (list of examples of routine physical examinations excluded from coverage) effective for services furnished on or after January 1, 2011. This expanded coverage is subject to certain eligibility and other limitations that allow payment for an annual wellness visit (AWV), including personalized prevention plan services (PPPS), for an individual who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage period, and has not received either an initial preventive physical examination (IPPE) or an AWV within the past 12 months.

The AWV will include the establishment of, or update to, the individual's medical/family history, measurement of his/her height, weight, body-mass index (BMI) or waist circumference, and blood pressure (BP), with the goal of health promotion and disease detection and encouraging patients to obtain the screening and preventive services that may already be covered and paid for under Medicare Part B. CMS amended 42 CFR §§411.15(a)(1) and 411.15(k)(15) to allow payment on or after January 1, 2011, for an AWV (as established at 42 CFR 410.15) when performed by qualified health professionals.

Coverage is available for an AWV that meets the following requirements:

1. It is performed by a health professional;

2. It is furnished to an eligible beneficiary who is no longer within 12 months after the effective date of his/her first Medicare Part B coverage period, and he/she has not received either an IPPE or an AWV providing PPPS within the past 12 months.

See Pub. 100-02,Medicare Benefit Policy Manual, chapter 15, section 280.5, for detailed policy regarding the AWV, including definitions of: (1) detection of cognitive impairment, (2) eligible beneficiary, (3) establishment of, or an update to, an individual's medical/family history, (4&5) first and subsequent AWVs providing PPPS, (6) health professional, and, (7) review of an individual's functional ability/level of safety.

140.1 – Healthcare Common Procedure Coding System (HCPCS) Coding for the AWV

(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

The HCPCS codes listed below were developed for the AWV benefit effective January 1, 2011, for individuals whose initial enrollment is on or after January 1, 2011.

G0438 - Annual wellness visit; includes a personalized prevention plan of service (PPPS); first visit

G0439 – Annual wellness visit; includes a personalized prevention plan of service (PPPS); subsequent visit

140.2 – A/B Medicare Administrative Contractor (MAC) and Carrier Billing Requirements

(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

Effective for dates of service on and after January 1, 2011, contractors shall recognize HCPCS codes G0438 and G0439 shown above in section 140.1 for billing AWVs. The type of service (TOS) for each of the new codes is 1. AWV services are paid under the Medicare Physician Fee Schedule (MPFS).

For further instructions regarding practitioner reporting of HCPCS codes G0438 and G0439 under different clinical scenarios, see chapter 12, sections 30.6.1.1 and 100.1.1 of this manual.

140.3 – A/B MAC and Fiscal Intermediary (FI) Billing Requirements

(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

The FI will pay for AWV services only when submitted on one of the following types of bill (TOBs): 12X, 13X, 22X, 23X, 71X, 77X, and 85X. Type of facility and setting determines the basis of payment:

- *For services performed on a 12X TOB and 13X TOB, hospital inpatient Part B and hospital outpatient, payment shall be made under the MPFS.*
- *For services performed in a skilled nursing facility, TOB 22X and TOB 23X, make payment based on the MPFS.*
- *For services performed on a 71X TOB, rural health clinic (RHC) or 77X TOB, Federally Qualified Health Center (FQHC), payment is made based on an all-inclusive rate and the AWV does not qualify for separate payment with another encounter.*
- *For services performed on an 85X TOB, Critical Access Hospital (CAH), pay based on reasonable cost.*
- *For services performed on an 85X TOB, CAH Method II, payment is based on the MPFS.*
- *For inpatient or outpatient services in hospitals in Maryland, make payment according to the Health Services Cost Review Commission.*

Only CAHs paid under the optional method are paid for professional services for the AWV (in addition to the facility payment) when those charges are reported under revenue codes 096X, 097X, or 098X.

140.4 – Rural Health Clinic (RHC)/Federally Qualified Health Center (FQHC) Special Billing Instructions

(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

Beginning with dates of service on or after January 1, 2011, if an AWV is provided in an RHC or FQHC, the professional portion of the service is billed to the FI or Part A MAC using TOBs 71X and 77X, respectively, and must include HCPCS code G0438 or G0439. Deductible and coinsurance do not apply.

140.5 – Coinsurance and Deductible

(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

Sections 4103 and 4104 of the Affordable Care Act provide for a waiver of Medicare coinsurance/copayment and Part B deductible requirements for the AWV effective for services furnished on or after January 1, 2011.

140.6 – Common Working File (CWF) Edits

(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

Effective for claims with dates of service on and after January 1, 2011, CWF shall reject:

- *AWV claims for HCPCS G0438 (first AWV) when a first AWV, HCPCS G0438, is paid in history, regardless of when it occurred. HCPCS G0438 is a once-in-a-lifetime benefit.*

- *AWV claims for HCPCS G0439 (subsequent AWV) when a previous AWV, HCPCS G0438 or G0439, is paid in history within the previous 12 months.*
- *AWV claims for HCPCS G0438 or G0439 when a previous IPPE, HCPCS code G0402, is paid in history within the previous 12 months.*

- *AWV claims for HCPCS G0438 or G0439 billed for a date of service within 12 months after the effective date of a beneficiary's first Medicare Part B coverage period.*

140.7 – Medicare Summary Notices (MSNs), Remittance Advice Remark Codes (RARCs), Claims Adjustment Reason Codes (CARCs), and Advance Beneficiary Notices (ABNs)

(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

Messages for Carriers, FIs, and A/B MACs:

When paying claims for an AWV, contractors shall use the following Medicare Summary Notices (MSNs):

MSN: 18.25: "Your Annual Wellness Visit has been approved. You will qualify for another Annual Wellness Visit 12 months after the date of this visit."

Spanish Version "Su Visita Anual de Bienestar ha sido aprobada. Usted tendrá derecho a otra Visita Anual de Bienestar 12 meses después de la fecha de esta visita."

When denying claims for a first AWV, HCPCS G0438, when a first AWV, HCPCS G0438, is already paid in history, contractors shall use the following messages:

MSN 20.12: "This service was denied because Medicare only covers this service once a lifetime."

Spanish Version: "Este servicio fue negado porque Medicare sólo cubre este servicio una vez en la vida."

CARC 149: "Lifetime benefit maximum has been reached for this service/benefit category."

RARC N117: "This service is paid only once in a patient's lifetime.

Group Code – PR

When denying claims for a subsequent AWV, HCPCS G0439, because a previous AWV, HCPCS G0438 or G0439, is paid in history within the past 12 months, contractors shall use the following messages:

MSN 18.26: "This service was denied because it occurred too soon after your last covered Annual Wellness Visit. Medicare only covers one Annual Wellness Visit within a 12 month period.'

Spanish Version: "Este servicio fue negado porque ocurrió antes del período de 12 meses de su última Visita Anual de Bienestar. Medicare sólo paga por una Visita Anual de Bienestar dentro de un período de 12 meses."

CARC 119: "Benefit maximum for this time period or occurrence has been reached."

RARC N130 "Consult plan benefit documents/guidelines for information about restrictions for this service."

Group Code – PR

When denying claims for an AWV, HCPCS G0438 or G0439, because an IPPE, HCPCS G0402, is paid in history with the past 12 months, contractors shall use the following messages:

(New) MSN 18.27: "This service was denied because it occurred too soon after your Initial Preventive Physical Exam."

Spanish Version: "Este servicio fue negado porque ocurrió demasiado pronto después de su examen físico preventivo inicial."

CARC 119: "Benefit maximum for this time period or occurrence has been reached."

RARC N130: "Consult plan benefit documents/guidelines for information about restrictions for this service."

Group Code – PR

When denying claims for an AWV, HCPCS G0438 or G0439, because the services were rendered within the first 12 months after the effective date of a beneficiary's first Medicare Part B coverage period, contractors shall use the following messages:

(New) MSN 18.24: "This service was denied. Medicare doesn't cover an Annual Wellness Visit within the first 12 months of your Medicare Part B coverage. Medicare does cover a one-time initial preventive physical exam ("Welcome to Medicare" physical exam) within the first 12 months of your Medicare Part B coverage".

Spanish Version: "Este servicio fue negado. Medicare no cubre la Visita Anual de Bienestar durante los primeros 12 meses de su inscripción a la Parte B de Medicare. Medicare cubre un examen físico preventivo ("Bienvenido a Medicare") durante los primeros 12 meses de su inscripción a la Parte B de Medicare."

CARC 26: "Expenses incurred prior to coverage"

RARC N130: "Consult plan benefit documents/guidelines for information about restrictions for this service."

Group Code – PR